

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00542

100

546 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|---|------------------------------|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <i>Charles</i> CITY (If outside corporate limits, write RURAL OR end give nearest town) <i>Waldorf</i> TOWN <i>Colo</i> | | STATE <i>Md.</i> COUNTY <i>Charles</i> CITY (If outside corporate limits, write RURAL end give nearest town) <i>Waldorf</i> TOWN <i>F.</i> | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| <i>James A. Arneson</i> (First) <i>James</i> (Middle) <i>A.</i> (Last) <i>Arneson</i> | | (Month) <i>Jan</i> (Day) <i>7</i> (Year) <i>1957</i> | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH |
| <i>Male</i> | <i>White</i> | <i>Married</i> | <i>12-18-88</i> |
| 9. AGE last birthday | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| <i>68</i> | <i>Retired Pepto Employee</i> | <i>Wash. D.C.</i> | <i>U.S.A.</i> |
| 13. FATHER'S NAME | 14. MOTHER'S M AIDEN NAME | | |
| <i>Adolph Arneson</i> | | <i>EMMA Taylor</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | 16. SOCIAL SECURITY NO. | | |
| <i>No</i> | <i>EMMA L. Birkhead - sister</i> | | |
| 17. INFORMANT & ADDRESS | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) <i>Conc St. Failure</i> ANTECEDENT CAUSE(S) DUE TO <i>Reportive Heart Disease</i> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>?</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION | | <i>1-5-57</i> | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at 10:29 A.M. from the causes and on the date stated above. SIGNATURE <i>Julie Posen</i> DATE SIGNED <i>1-5-57</i> 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> DATE THEREOF <i>1-11-1957</i> NAME OF CEMETERY OR Crematory <i>Cedar Hill</i> LOCATION (City, town, or county) <i>Suitland, Md.</i> (State) <i>MD</i> 24. REC'D BY REGISTRAR DATE <i>JAN 11 1957</i> REGISTRAR'S SIGNATURE <i>Julie Posen</i> 25. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co.</i> ADDRESS <i>Wash, D.C.</i> | | | |

OF URGENT-URGENT TO THE STATE-STATE

STATE-STATE

RECEIVED BY TELETYPE

1957 JAN 11 1057

BUREAU U. S.

JAN 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00543

| | | | | | | | | |
|--|--|--|--|---|--|--------------------------------|------------------------------|------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 547 CHARLES County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | MARYLAND b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b BRYANTOWN life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | d. STREET ADDRESS | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | RURAL | | BRYANTOWN | | None - RURAL | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First JAMES | Middle A. | Last BUTLER | 4. DATE OF DEATH | Month 1 | Day 26 | Year 1957 |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days | |
| Male | | Negro | | 2-21-20 | 36 yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| FARMER | | FARMING | | MARYLAND | | U.S.A. | | |
| 13. FATHER'S NAME | | James A. Butler Sr. | | 14. MOTHER'S MAIDEN NAME | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| NO | | 212 24 2672 | | WIFE MRS JAMES BUTLER - BRYANTOWN | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | CARBON MONOXIDE POISONING | | | | | | |
| 9160 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | | | | | |
| DUE TO (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| ACUTE Alcoholism. | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour 3 | | Month, Day, Year a. m. 1-26 1957 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) home | (County) BRYANTOWN-ENAS. MD | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | DATE SIGNED 1/27/57 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORIAL ST MARY'S CEM. BRYANTOWN MD | | 22d. LOCATION (City, town, or county) (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS Kerr General Home Waldorf, Md. | 24a. RECEIVED BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE Julia L. Tracy | | | |
| | | | | | DATE | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MANUFACTURED BY THE GOVERNMENT OF HAITI - PAINTED IN 1956
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JAN 29 1957

REGELIV E

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

548 CERTIFICATE OF DEATH

00544

Reg. Dist. No. 100

| | | | | | |
|---|---------------------------|--|---|--|---|
| 1. PLACE OF DEATH CITY <i>Charles County</i> TOWN <i>Saylors Bay</i> | | | 2. USUAL RESIDENCE (HOME) OF DECEASED CITY <i>MARYLAND</i> TOWN <i>Dentonsville</i> | | |
| 3. NAME OF DECEASED (Type or Print) <i>John Cole</i> | | | 4. DATE (Month) (Day) (Year) OF DEATH <i>12-29-57</i> | | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>C</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i></i> | 8. DATE OF BIRTH <i>4-21-06</i> | 9. AGE last birthday <i>51</i> | IF UNDER 1 YEAR Months <i>8</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Painting</i> | | 11. BIRTHPLACE (State or foreign country) <i>Charles Co. Md.</i> | |
| 13. FATHER'S NAME <i>Thomas Cole</i> | | 14. MOTHER'S M AIDEN NAME <i>MARY Jennifer</i> | | 12. CITIZEN OF WHAT COUNTRY? <i></i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> | | 16. SOCIAL SECURITY NO. <i></i> | | 17. INFORMANT & ADDRESS <i></i> | |
| 18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE <i>571.0</i> (A) <i>Gastritis</i> DUE TO <i>Franklin</i> 12-29-57 ANTECEDENT CAUSE(S) DUE TO <i>Inf. disease</i> 12-29-57 DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO <i></i> STATING UNDERLYING CAUSE LAST. (C) <i></i> | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i></i> | | | | | |
| 19a. DATE OF OPERATION <i></i> | | 19b. MAJOR FINDINGS OF OPERATION <i></i> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i> | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i></i> | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <i></i> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>M.</i> | | 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <i></i> | |
| 22. I hereby certify that I attended the deceased from <i>12-29-57</i> to <i>1-2-58</i> , that I last saw the deceased alive on <i>1-2-58</i> , and that death occurred at <i>2 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>John Cole</i> M.D. DATE SIGNED <i>1-2-58</i> | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | DATE THEREOF <i>Jan 4 1958</i> | | NAME OF CEMETERY OR CREMATORIAL <i>St. Marys</i> | |
| 24. REC'D BY REGISTRAR DATE <i>1/8/57</i> | | REGISTRAR'S SIGNATURE <i>Julia H. Passey</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Archard Inc. Landstal, Md.</i> | |

BUREAU A.

JAN 10 1957

REGELIV ED

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00545

549 CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH

COUNTY Charles

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN La Plata

MARYLAND

LENGTH OF STAY
(in this place)**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Maryland

COUNTY Charles

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Spring Hill

STREET ADDRESS
(If rural give location)HOSPITAL
INSTITUTION OR
STREET ADDRESS

Physicians Memorial Hospital

**3. NAME OF
DECEASED**
(Type or Print)

(First) Male

(Middle) Infant

(Last) Cooksey

**4. DATE OF
DEATH** (Month) (Day) (Year)
January 16, 1957

5. SEX

Male

6. COLOR OR
RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

single

8. DATE OF BIRTH

January 16, 1957

9. AGE last birthday

yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Infant

11b. KIND OF BUSINESS
OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

La Plata Maryland

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME

Howard Rudolph Cooksey

14. MOTHER'S MAIDEN NAME

Dorothy Ann Fay

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)

no

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT & ADDRESS

Howard Cooksey, Spring Hill, Maryland

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN
ONSET AND DEATH

IMMEDIATE CAUSE

(A)

Prematurity, not consistent with survival (5 $\frac{1}{2}$ mos.) 1' 5"

ANTECEDENT CAUSE(S)

DUE TO

Weight 1 lb, 10 oz.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-16-57, 19....., to 1-16-57, 19....., that I last saw the deceased
alive on 1-16-57, 19....., and that death occurred at 4:15 P.M. from the causes and on the date stated above.

SIGNATURE

John H. Griffin, M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

Hughesville, Md.

1-16-57

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

1-17-57

NAME OF CEMETERY OR CREMATORIAL

Dentsville, M.E.

LOCATION (City, town, or county)

(State)

Spring Hill, Maryland

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

Julia H. Pasey

25. FUNERAL DIRECTOR'S SIGNATURE

Richard J. LaPlata, M.D.

ADDRESS

DATE 1/17/57

2016323XVO

STATE CERTIFICATE OF DEATH

NAME OF DECEASED PERSON

DEATH
DATE

DEATH
DATE

ST. LO
I. T. A. M.

DEATH CERTIFICATE

BUREAU V. S.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00546

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

550

Item 14 Film G209 1-18-57 et

Reg. Dist. No. 100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | |
|--|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Charles MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Wash., D.C. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldford | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Ernest F. Downs | | 4. DATE OF DEATH 3-11-1896 | Month 1 Day 9 Year 1957 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-11-1896 |
| 9. AGE (In years months/ days) 60 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Hauler | | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Tom Downs | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. W.W. / | |
| 17. INFORMANT Francis W. Downs, 2209 Lakewood St. Suitland, Md. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c) | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | 22. DATE THEREOF 1-14-57 | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) William J. Kurz, M.D. | | DATE SIGNED 1-9-'57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Cerberus Inc. La Plata Md | | 22d. LOCATION (City, town, or county) Arlington Co (State) | |
| ADDRESS | | 24a. REC'D BY REGISTRAR 1/11/57 | |
| 24b. REGISTRAR'S SIGNATURE June H. Pasey | | | |

DEPARTMENT OF JUSTICE - FEDERAL BUREAU OF INVESTIGATION
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU U. S.

JAN 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

551

CERTIFICATE OF DEATH

00547
100

Reg. Dist. No.

| | | | | | |
|---|---------------------|--|---|---------------------|--|
| 1. PLACE OF DEATH a. COUNTY | CHARLES MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE | MARYLAND CHARLES | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | Rural - Hughesville | | c. LENGTH OF STAY IN 1b | 2 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | Rural - Hughesville | |
| | | | d. STREET ADDRESS | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |

| | | | | | | | |
|--|-------|--------|------|------------------|-------|------|------|
| 3. NAME OF DECEASED (Type or print) | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year |
| MARY LAURA LEE FORD | | | | JAN. | 18 | 1957 | |

| | | | | | | |
|--------------|------------------|--|------------------|------------------------------------|-------------------------------|------------------------------|
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days |
| Female Negro | | DIVORCED <input type="checkbox"/> | JAN 10, 1885 | 7 yrs. | | |

| | | | |
|---|-----------------------------------|---|------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| Housewife | Home | St. Marys Co. Md | USA |

| | |
|-------------------|--------------------------|
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| ABRAHAM BRISCOE | CHARISSA JENIFER |

| | | | |
|---|-------------------------|-------------------------------------|---------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
| NO | | Husband - Robert Ford - Hughesville | |

| | |
|--|-------------------------------------|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | 3 days |
| 443X | Acute Myocardial Failure |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | |
| (b) | Chronic Myocardial Heart Disease |
| DUE TO | Years |
| (c) | Chronic Hypertension |
| DUE TO | Years |

| | | |
|--|--|---|
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|--|--|---|

| | | |
|---|---|---|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |

| | | |
|---|---------------------------------------|-------------|
| 21. I certify that I attended the deceased from Sept 17, 1955, to Jan 18, 1957, that I last saw the deceased alive on Jan 18, 1957, and that death occurred at 8:10 P.M., from the causes and on the date stated above. | ADDRESS (Street, city or town, state) | DATE SIGNED |
|---|---------------------------------------|-------------|

| | | | |
|------------------------------------|------|---------|------|
| ACTUAL SIGNATURE V. M. SERON MD | M.D. | ADDRESS | DATE |
| PHYSICIAN'S NAME (Type) | | | |

| | | | |
|---|-------------------|--------------------------------------|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORIAL | 22d. LOCATION (City, town, or county) (State) |
| Burial | 1-21-57 | St. Marys Episcopal Cem. | New Market Md. |

| | | | |
|----------------------------------|-------------|-------------------------|----------------------------|
| 23. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE |
| Short Funeral Home | Warder, Md. | DATE | JULIA COOPER |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 |
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JAN 21 1957

RECEIVED

JAN 21 1957

JAN 21 1957

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00548

552 CERTIFICATE OF DEATH

Reg. Dist. No. 105

| | | | |
|--|-----------------------------|--|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN | CHARLES RURAL - WALDORF | MARYLAND LENGTH OF STAY (in this place) | STATE MARYLAND COUNTY CHARLES CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <input checked="" type="checkbox"/> RURAL - WALDORF STREET ADDRESS (If rural give location) |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | — | | |
| 3. NAME OF DECEASED (Type or Print) | | (First) (Middle) (Last) | |
| MARY F HAMILTON | | 4. DATE (Month) OF DEATH Jan 12 1957 (Day) (Year) | |
| 5. SEX Female | 6. COLOR OR RACE US-W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH Aug. 19, 1867 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY home | |
| 13. FATHER'S NAME Edward Hamilton | | 14. MOTHER'S MAIDEN NAME McDavid | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT & ADDRESS Ethel Robey White Plains, Md. | | 18. MEDICAL CERTIFICATION | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) <u>Respiratory collapse</u> ANTECEDENT CAUSE(S) DUE TO <u>Congestive heart failure</u> DISEASES OR CONDITIONS, IF ANY, (B) <u>Arteriosclerotic heart disease</u> GIVING RISE TO THE ABOVE CAUSE DUE TO <u>STATE UNDERLYING CAUSE LAST</u> STATING (C) | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 2 whs. 4 years. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| M. | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Augmt. 1952</u> to <u>January 1957</u> , that I last saw the deceased alive on <u>Jan. 12, 1957</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Howard</u> ADDRESS (Street, city, town, state) <u>La Plata, Maryland</u> DATE SIGNED <u>12 Jan 57</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 1-14-57 | |
| 24. REC'D BY REGISTRAR DATE <u>JAN 16 1957</u> | | REGISTRAR'S SIGNATURE <u>Mrs. M. L. Monroe</u> | |
| 25. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home | | ADDRESS Waldorf, Md. | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be retained within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00549

55 CERTIFICATE OF DEATH

Reg. Dist. No. 100

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY CHARLES | MARYLAND | STATE MARYLAND | COUNTY CHARLES |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| TOWN LA PLATA | 4 DAYS X0 | TOWN HUGHESVILLE | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians' MEMORIAL HOSPITAL | | STREET ADDRESS ROUTE #5 | (If rural give location) |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE (Month) (Day) (Year) | |
| Gary Keith LAW | | JANUARY 27 1957 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE | 8. DATE OF BIRTH Dec. 2 1951 |
| 9. AGE last birthday 1 yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Harnie L. Law | 14. MOTHER'S MAIDEN NAME Helen M. Hill | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT & ADDRESS Harnie L. Law Md. | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 286.0 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) | | INTERVAL BETWEEN ONSET AND DEATH 5 DAYS | |
| CELIAC DISEASE | | 13 MONTHS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from JANUARY 27 1957, to JANUARY 27 1957, that I last saw the deceased alive on JANUARY 27 1957, and that death occurred at 8:30 PM, from the causes and on the date stated above. SIGNATURE John N. Guffin M.D. | | | |
| ADDRESS (Street, city, town, state) DATE SIGNED Box #65; HUGHESVILLE MD. 1/28/57 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Jan. 29 1957 | NAME OF CEMETERY OR CREMATORIAL St. Josephs. | LOCATION (City, town, or county) (State) Morganza Md. |
| 24. REC'D BY REGISTRAR | REGISTRAR'S SIGNATURE Julia Posey | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hunt Funeral Home, Waldorf Md. | |
| DATE JAN 31 1957 | | | |

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGON, D. C.

EXHIBIT SHEET OF DATE

BUREAU V. A.
RECEIVED
JAN 31 1957

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. After this copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 4-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00550

CERTIFICATE OF DEATH

554

Reg. Dist. No. 100

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN | Charles La Plata | MARYLAND LENGTH OF STAY (in this place) | STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | Physicians Memorial Hosp. | | |
| 3. NAME OF DECEASED (Type or Print) | (First) Jonah | (Middle) J. | (Last) NEWTON |
| 4. DATE OF DEATH | Jan 28 1957 | | |
| 5. SEX Male | 6. COLOR OR RACE US-W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH Nov 29 1885 |
| 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) not mfg. | 10b. KIND OF BUSINESS OR INDUSTRY Jewelry | 11. BIRTHPLACE (State or foreign country) MASS. | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME ALONZO NEWTON | 14. MOTHER'S MAIDEN NAME Miranda A. Potton | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) yes | 16. SOCIAL SECURITY NO. 135 10 0645 | 17. INFORMANT & ADDRESS Bessie G. Newton La Plata, Md. | 18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) Cardio-respiratory failure ANTECEDENT CAUSE(S) DUE TO Myocardial infarction DISEASES OR CONDITIONS, IF ANY, (B) Arteriosclerotic heart disease GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Tumor of Rt kidney INTERVAL BETWEEN ONSET AND DEATH 3 days. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 10 days. 3 years |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | (County) (State) |
| | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from <u>Jan</u>, 1957, to <u>28 Jan</u>, 1957, that I last saw the deceased alive on <u>28 Jan</u>, 1957, and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above. | | | |
| SIGNATURE <i>Dorothy</i> | | ADDRESS (Street, city, town, state) La Plata, Md. DATE SIGNED 28 Jan 77 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 1-30-57 | NAME OF CEMETERY OR CREMATORIAL Mt Rest com. | LOCATION (City, town, or county) La Plata, Md. (State) |
| 24. REC'D BY REGISTRAR DATE JAN 31 1957 | REGISTRAR'S SIGNATURE Julia Posay | 25. FUNERAL DIRECTOR'S SIGNATURE Huntt. Funeral Home - Waldorf, Md. | ADDRESS |

BUREAU V.

JAN 31 1957

REGELVFD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00551
100

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in our files.
 GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | | | |
|--|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY | | Charles MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Charles | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cobb Island, Md. | | c. LENGTH OF STAY IN lb Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Cobb Island | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First James | Middle Andrew | Last Shymansky, Jr. | 4. DATE OF DEATH Month 1 Day 4 Year 1957 |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH July 12, 1942 | 9. AGE (In years last birthday) 14 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY Student | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME James Andrew Shymansky | | 14. MOTHER'S MAIDEN NAME Margaret Spalding | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs James A Shymansky Cobb Island | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 919.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gun shot wound left chest DUE TO (c) | | | | Address INTERVAL BETWEEN ONSET AND DEATH 1-4-57 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gun discharged accidentally (his) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. TIME OF INJURY Hour a. m. 11 p. m. 1-4 1957 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River Shore | |
| 20f. (City or town) Cobb Island, Charles, Md. | | | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) E. J. Edelen, M.D. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 1-5-'57 | |
| | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-7-57 | | 22c. NAME OF CEMETERY OR CREMATORIAL Holy Ghost | |
| 22d. LOCATION (City, town, or county) Isaac | | | | (State) Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 24a. REC'D BY REGISTRAR Julia N. Parry DATE 1/7/57 | |
| Reharts Inc. Cpl. No. 11757 | | | | 24b. REGISTRAR'S SIGNATURE | |

WILSON-STRATTON-HEATH-GARMINONE 28
MEDICAL EXAMINER CERTIFICATE OF DEATH

BUREAU V. S

JAN 10 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
558 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00552
100

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Charles</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Charles</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>o Bryantown</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First <i>Paul</i> | Middle <i>Adrin</i> | Last <i>Sweetney</i> |
| 4. DATE OF DEATH | Month 1 | Day 19 | Year 1957 |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>N</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>1924</i> |
| 9. AGE (In years last birthday) <i>32</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i> | 11. KIND OF BUSINESS OR INDUSTRY <i>—</i> | 12. BIRTHPLACE (State or foreign country) <i>nd.</i> |
| 13. CITIZEN OF WHAT COUNTRY? <i>USA</i> | 14. FATHER'S NAME <i>Albert Sweetney</i> | 15. MOTHER'S MAIDEN NAME <i>Lessie Duckett</i> | 16. SOCIAL SECURITY NO. <i>517-28-4580</i> |
| 17. INFORMANT <i>Albert Sweetney Bryantown, Md.</i> | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Exposure</i> <i>932.9</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Alcoholism and</i> <i>lying in snow & ice at 10° temp</i> | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | Address <i>1-19-57</i> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) <i>Chas.</i> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>E. J. EDELEN</i> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <i>1-21-57</i> |
| 22a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>1-22-57</i> | 22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Mary's Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Bryantown, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Hurst Funeral Home</i> | ADDRESS <i>Wadsworth, Md.</i> | 24a. REC'D BY REGISTRAR DATE <i>JAN 23 1957</i> | 24b. REGISTRAR'S SIGNATURE <i>Julia Posey</i> |

BUREAU V. S

JAN 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10553

| | | | | | | | | | | | | | | |
|--|--|--|-----------------------------------|---|-------------------------|--|---|---------------------------------|------------------------------|-----------------|--------|-------------------|---|--|
| 1 | | 557 | | | | | | | | | | 2 | | |
| 1. PLACE OF DEATH a. COUNTY | | Charles | | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | | Maryland | | | b. COUNTY Charles | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Waldorf | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Waldorf | | | d. STREET ADDRESS | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | | | | | | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Frances | | Middle E. | | Last Walker | | 4. DATE OF DEATH | | Month 1 | Day 17 | Year 1957 | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Female | | White | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | Aug. 29, 1903 | | 53 yrs. | | Months | Days | Hours | Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| housewife | | | home | | | Virginia | | | USA | | | | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Walter Crosen | | | unk | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | |
| NO | | | none | | | Calvin L. Walker | | | Center St SE Washington, DC | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH Sudden | | | | | | | | | | | | | | |
| 420.1 DUE TO | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO | | | | | | | | | | | | | | |
| 250x (c) | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? | | | | | | | | | | | | | | |
| History of Diabetes untreated YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month, Day, Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>E. J. Edelen</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | DATE SIGNED 1-17-'57 | |
| EXAMINER'S NAME (Type) E. J. Edelen, M.D. | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-19-57 | | 22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cem. | | 22d. LOCATION (City, town, or county) Suitland, Maryland | | (State) | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The Huntt Funeral Home - Waldorf, Md. | | ADDRESS | | | | | | | | | | | | |
| | | 24a. REC'D BY REGISTRAR JAN 21 1957 | | | | | | | | | | | 24b. REGISTRAR'S SIGNATURE <i>M. L. Monroe</i> | |
| VS. A15ME(5) 5M 9/55 | | | | | | | | | | | | | | |

WEDDING EXAMINER CERTIFICATE OF DEATH

BUREAU V. S.

JAN 21 1957

RECEIVED